**MEDICAL ASSESSMENT**

**Part 1: Recognition that the patient is dying**

The decision relating to the patient’s prognosis must be endorsed by the most senior clinician responsible for the patient’s care (Consultant / GP) at the earliest opportunity.

**Date** ………… **Time** ………… **Place of care** …………………………………………….….

**Responsible consultant/GP**: …………………………… **GP Practice**:……………………

If the clinical impression is that the patient may die in the next hours or days please document the key information which supports this decision including efforts to correct reversible causes where relevant:……………………………………………………………………………………….

…………………………………………………………………………………………………………..

What is the likely cause of death?...........................................................................................

**Part 2: Mental Capacity Assessment and Advance Care Planning**

**Does the patient have capacity** to make decisions regarding current and future treatment plans (including nutrition and hydration if swallow unsafe)? **Yes / No**

*If the patient lacks capacity, best interests decisions should be made in line with the MCA 2005, including consideration of any preferences previously expressed by the patient. Further information regarding assessment of capacity and decision making is available at* [*www.northerncanceralliance.nhs.uk/decidingright*](http://www.northerncanceralliance.nhs.uk/decidingright) *and use your organisation’s MCA documentation where appropriate.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the patient have any of these documents?** | **Y/N** | **Viewed** | **Location**  |
| **Do Not Attempt CardioPulmonary Resuscitation(DNACPR) –*valid, applicable and in date*** | **YES****essential** | Y / N |  |
| Advance Decision to Refuse Treatment (ADRT)  |  | Y / N |  |
| Advance Statement |  | Y /N |  |
| Emergency Health Care Plan (EHCP) |  | Y / N |  |
| LPA for Health and Welfare  |  | Y / N |  |

LPA name………………………… LPA contact details…………………………………………..

Has the patient opted out of organ donation? **Yes / No** *(If no, consider* *referral for donation)*

Are there any additional expressed wishes or decisions?.....................................................

**What is the patient’s current preferred place of death?**:……………………….…………….

Is this likely to be achieved? **Yes / No** If no, why not?…………………………………………

………………………………………………………………………………………………………….

**Part 3: Decisions about life-sustaining treatments and interventions**

Implanted cardiac defibrillator **Yes / No**

Has it been deactivated? **Yes / No** If not, what is plan for deactivation?.............................. ……………………………………………………………………………………………………….…

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current treatments / interventions** | **Not being taken / given** | **Continued / commenced**  | **Discontinued** | **Comments** |
| CPAP / BiPAP ventilation |  |  |  |  |
| Oxygen therapy |  |  |  |  |
| Renal replacement therapy (dialysis) |  |  |  |  |
| Antibiotics |  |  |  |  |
| Routine blood tests |  |  |  |  |
| Blood glucose monitoring  |  |  |  |  |
| Recording of routine vital signs |  |  |  |  |
| Other |  |  |  |  |

**Part 4: Nutrition and Hydration**

***N.B.*** *If the patient expresses a wish to eat or drink, staff should offer* ***assistance*** *when required.* ***Even if there are concerns that a patient’s swallow is impaired or unsafe, the patient******may still elect to eat and drink.*** *If the patient has mental capacity and understands the risk of aspiration, oral food and fluids must* ***NOT*** *be withheld from a patient who wishes to eat and drink.* ***For patients who do not have mental capacity****, decisions regarding eating/drinking should be made using the best interests process as detailed in section 2.*

Are there any concerns that the patient’s swallow is impaired / unsafe? **Yes / No**

**Nutrition**

Please document decisions regarding oral, enteral or parenteral nutrition (including any risks and benefits): ……………….………………………………………………………………………………….

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**Hydration**

Please document decisions regarding oral or parenteral hydration (including any risks and benefits……………………………………………………………………………………………………..:

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**Part 5: Symptom Management and Review of Medications**

*Review all medication and decide which are necessary for ongoing disease management and symptom control. Consider prescribing essential medication via non-oral routes. For guidance, see NECN Palliative and End of Life Care Guidelines for Symptom Control available at https://www.northerncanceralliance.nhs.uk/pathway/palliative-and-end-of-life-care/supportive-palliative-and-end-of-life-care-resources/*

**Record a management plan for any existing symptoms, long term conditions or treatments** (including if unable to take oral medication)eg seizures, diabetes, Parkinson’s disease, long term steroids …………………………………..……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

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**Prescribe anticipatory medication for the following potential symptoms.**

**Note: CONSIDER RENAL IMPAIRMENT WHEN PRESCRIBING.**

|  |  |
| --- | --- |
| **Symptom** | **Prescribed** |
| Pain |  |
| Nausea and vomiting |  |
| Agitation/restlessness |  |
| Breathlessness |  |
| Respiratory secretions |  |

**Part 6: Discussion of plan with patient and/or relative/carer**.

**Please record who was present during discussion:**

Patient **Yes / No** If not, state reason………………………………………………………….

Staff member(s): …………………………………………………………………….………………

Relative/Carer/other(s) ……………………………………………………………….……...……..

**Please ensure that you have discussed all of the following:**

|  |  |  |
| --- | --- | --- |
| **Discussed plan/rationale for** | **With patient** | **With relative/carer** |
| Part 1: Recognition of dying |  |  |
| Part 2: MCA/advance care planning including DNACPR |  |  |
| Part 3: Decisions re: treatments/interventions |  |  |
| Part 4: Nutrition and hydration |  |  |
| Part 5: Symptom management / medications |  |  |

**Summary of discussion** …………………………………………………………………………..………………………………………………………………………………………………………….………………………………………………………………………………………………………….…………………………………………………………………………………………………………

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Has the rationale for medication changes (including, for example, the use of opioids/sedative) been discussed with: Patient? **Yes / No** Relative/Carer? **Yes / No**

Has possibility of side effects of medications (eg drowsiness) been discussed with:

 Patient? **Yes / No** Relative/Carer? **Yes / No**

If prescribed medication is to be administered via a subcutaneous infusion (syringe driver), who has this been discussed with? **Patient Relative/carer Not required**

**Part 7: Verification of Expected Death**

Can this patient’s death be verified by an appropriately trained registered nurse? **Yes / No** If no, please state the reason:……………………………………………………………………...

Does this patient’s death need to be referred to the coroner? **Yes / No**

If yes, please state the reason: ……………………………………………………………………..

Name of relative/carer informed? ..............................................................................................

**Part 8: Plan documented by**

Signature: Date: Time:

Print name: Designation: GMC/NMC

**Endorsement by senior clinician:**

Signature: …………………………….. Date: …………………………….Time:………………….

Print name: Designation: GMC/NMC